Allergies:_____ **Meds:**_____

MEDICAL SCREENING FORM
SERE/CWEST TRAINING

Part A: To be filled out by student

_____	_____	_____
Name: (Last, First, MI)	Rank/Rate	SSN

_____	_____	_____	_____
Age	Unit	Weight	Class Number

Circle YES or NO: Do you currently have or ever had

YES	**NO**	Temporary caps or fillings	**YES**	**NO**	Immersion/Trench Foot
YES	**NO**	Jaw Trouble	**YES**	**NO**	Frost Bite
YES	**NO**	Braces	**YES**	**NO**	High Blood Pressure
YES	**NO**	Implants	**YES**	**NO**	Heart Disease/Murmur
YES	**NO**	Crowns	**YES**	**NO**	Deep Vein Thrombosis
YES	**NO**	Maryland Bridge	**YES**	**NO**	Stroke/CVA
YES	**NO**	Retained Hardware (Dental) (Ortho Screws, Pins, Plates)	**YES**	**NO**	Allergy to Medications
YES	**NO**	Shoulder Trouble	**YES**	**NO**	Allergy to Bee Stings
YES	**NO**	Fracture of the Neck or Back	**YES**	**NO**	Diabetes
YES	**NO**	Back Trouble	**YES**	**NO**	Lung Disease
YES	**NO**	Deformity of the Back	**YES**	**NO**	Shortness of Breath
YES	**NO**	Injury to the Hip,Knee,Ankle	**YES**	**NO**	Crohns Disease/IBS
YES	**NO**	Neurological Problems	**YES**	**NO**	GERD
YES	**NO**	Shingles	**YES**	**NO**	Ulcers/Gastritis
YES	**NO**	Heat Stroke	**YES**	**NO**	Kidney/Bile Duct Stones
YES	**NO**	Heat Exhaustion	**YES**	**NO**	Internal Med Condition
YES	**NO**	Hypothermia	**YES**	**NO**	Claustrophobia

YES **NO** Negative Life Experience in last year (Death of family member, Training Mishap, Divorce)

YES **NO** Have you seen a Doctor in the Last **90 days** for other than a Flight Physical?

YES **NO** Do you currently have a sore throat or cold?

YES **NO** Are you currently taking any medications?

YES **NO** Do you need to see a Flight Surgeon at this time?

YES **NO** Do you need to see a Psychologist at this time?

YES **NO** Have you ever been diagnosed with mental disorder/condition? (depression, anxiety disorder, PTSD, etc.)

Additional Comments: Explain all "YES" responses to the above questions.

Have you had in the past 180 days:

YES	**NO**	Pneumonia	**YES**	**NO**	Yellow Jaundice
YES	**NO**	Sprains/Strains	**YES**	**NO**	Hospitalization
YES	**NO**	Rupture Ear Drum/Baro Trauma	**YES**	**NO**	Surgery
YES	**NO**	Hernia	**YES**	**NO**	Fractured Bones

FEMALES ONLY:

YES **NO** Are you menstruating?
YES **NO** Currently taking birth control?
YES **NO** Could you be pregnant?

Additional Comments: Explain all "YES" responses to the above questions. List any medical concerns you may have about your SERE training.

I certify I have truthfully and completely answered all questions.

_____ _____
Signature **Date**

Part B: To be filled out by the examining physician.

S:

O:

H:

E:

E:

N:

T:

NECK

HEART

LUNGS

ABDOMEN

MUSCLES/SKELETAL

NEUROLOGICAL

Additional comments and information:

A:

Student is physically qualified for SERE/CWEST training at this time. YES NO

P:

Examining physician:

_____

Signature **Date**

Stamp or printed information:

FASOTRAGRULANT FORM 6120/01 (APR 06)